U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 22 September 2005

IN THE MATTER OF:

HIRAM ACORD,
Claimant,

v. Case No.: 2003-BLA-6585

EASTERN ASSOCIATED COAL CORP.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Mary Natkin, Esquire
Brooke Corby, Lay Representative
For the Claimant:

Paul Frampton, Esquire
For the Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725 (2001). A hearing was held in Beckley, West Virginia on November 9, 2004. The decision in this matter is based upon the testimony of Claimant at the hearing, all documentary evidence admitted into the record at the hearing, and the post-hearing arguments of the parties. The documentary evidence admitted at the hearing includes *Director's Exhibits* (*DX*) 1-40, *Claimant's Exhibits* (*CX*) 1-8, and *Employer's Exhibits (EX)* 1-4.[1]

1. Employer stated at the hearing that the deposition transcripts of Drs. Zaldivar and Branscomb were to be submitted post-hearing as EX 5 and 6. However, these submissions were never made and the record is now closed.

Overview of the Black Lung Benefits Program

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

Factual and Procedural History

Hiram Acord, hereinafter Claimant or the miner, filed his first claim for benefits under the Act on June 2, 1993. (DX 1). This claim was ultimately denied in November of the same year. (DX 1). On March 16, 2000, the miner filed his second claim for benefits, which was denied on August 11, 2000. (DX 2). On September 26, 2001, the miner filed this current claim for benefits. (DX 3). The current claim was filed over a year after the denial of the miner's previous claim, and therefore it is a subsequent claim. The miner was awarded benefits by the district director on May 13, 2003. (DX 30). The employer requested a formal hearing, and the claim was referred to the Office of Administrative Law Judges on June 16, 2003. (DX 31, 32).

Claimant retired in 1998 after approximately twenty years of underground coal mine employment. (TR 21, 29). Claimant's last coal mine job was as a general laborer, and his duties included rock dusting, timbering, cleaning and installing the belt. (TR 20-21). Claimant stated that timbering was the hardest part of his job because at times it required him to carry timbers for thousands of feet. (TR 21). The miner began to notice his breathing problems in the early 1980s, and currently he experiences shortness of breath when walking. (TR 22). Claimant believes that he would be unable to perform his last coal mine job due to his breathing difficulties. (TR 21).

The miner is married to his wife, Shirley, and has no other dependents. (TR 19). He smoked cigarettes from 1964 to 2000, at the rate of a pack a day. (TR 23 and DX 12). Claimant's treating physician is Dr. Doyle, who currently treats him at least four times a year, and who began seeing him in the 1980s. (TR 24). The miner has been prescribed Flovent and Combivent to treat his breathing problems. (TR 22).

Issues Presented for Adjudication, Stipulations and Findings

The issues listed as contested on the CM-1025 include: (1) whether the miner suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) whether he is totally disabled; (4) whether the miner's total disability was due to pneumoconiosis; (5) whether a material change in condition has occurred; (6) dependency; (7) responsible operator and (8) length of coal mine employment. (DX 37).

The parties have stipulated that the miner has at least seventeen years and ten months of coal mine employment. (TR 8). The miner testified regarding his marriage to his wife, Shirley, and presented a copy of his marriage certificate. (TR 19, DX 10). The miner has proved that he

has one dependent. The Claimant has also proven that he was last employed for a year or more as a coal miner with Eastern Associated Coal Corporation. Claimant offered testimony, and Social Security records which support the finding that Eastern was his last employer, and no contradictory evidence exists on the record. Therefore, the district director designated the proper responsible operator in this case. The remaining issues for adjudication are material change in condition and the four elements of entitlement.

The Standard for Entitlement

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718 (2001).[2] Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Evidence which is in equipoise is insufficient to sustain Claimant's burden in this regard. *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), *aff'd sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3rd Cir. 1993). Failure to establish any one these elements precludes entitlement to benefits.

The instant claim is considered a subsequent claim because the Claimant filed the claim over a year after his previous claim was denied. In a subsequent claim, a de novo review of the evidence of record is appropriate if, as a threshold matter, a material change in condition has been demonstrated. 20 C.F.R. § 725.309. A material change in condition relates to the Claimant's physical condition, and the newly submitted evidence must be sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. § 725.309(d). Therefore, the claimant must demonstrate that his or her condition has materially changed since the earlier denial of benefits. *See Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995) *aff'd*, 86 F.3d 1358 (4th Cir. 1996) (en banc) *cert. denied*, 117 S.Ct. 763 (1997).

In this case, the Claimant's previous claim was denied because he was found not to have established any of the elements of entitlement. The newly submitted evidence establishes a material change in condition. Claimant has established by a preponderance of the newly submitted evidence that he is now totally disabled. Because the newly submitted evidence is sufficient to demonstrate an element of entitlement, total disability, which was previously adjudicated against the Claimant, the entire record will be reviewed de novo.

Material Change in Condition-Total Disability

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2001). The regulations further state the following:

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2. As the claimant last engaged in coal mine employment in the State of West Virginia, appellate jurisdiction of this matter lies with the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

20 C.F.R. § 718.204(a) (2001).

Twenty C.F.R. § 718.204(b) (2001) provides the following five methods to establish total disability: (1) qualifying pulmonary function studies; (2) qualifying blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure;[3] (4) reasoned medical opinions; and (5) lay testimony. [4]

Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 (2001) and require, in relevant part, that (1) each study be accompanied by three tracings, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), (2) the reported FEV1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for claims filed after January 19, 2001, a flow-volume loop must be provided. The administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 and either the (1) MVV or the (2) FVC values must be equal to or fall below those values listed at Appendix B for a miner of similar gender, age, and height, or (3) the FEV1 / FVC ratio is 55% or less. The following pulmonary function studies were submitted in the current claim:

Exhibit	Date	Height	Age	FEV1	FVC	FEV1/ FVC	MVV	Qualifying?
CX 1	08/06/01	67"	64	1.49 1.68*	2.87 3.16*	52% 53%	--- ---	Yes Yes
DX 14	11/08/01	67"	64	1.50 1.98*	2.62 3.68*	57% 54%	62 92*	Yes No
DX 29	05/08/02	68"	65	1.54 1.73*	2.84 3.10*	54% 56%	65 71*	Yes Yes
CX 2	02/04/03	68"	65	1.74 1.93*	2.87 2.96*	61% 65%	88 77*	No No
EX 2	04/28/04	68"	67	1.34 1.80*	2.54 3.30*	53% 55%	--- ---	Yes Yes

3. There is no evidence of cor pulmonale with right-sided congestive heart failure such that this method of establishing total disability will not be discussed further.

4. The Board holds that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

*results post-bronchodilator

Based upon the foregoing, the Claimant has established total disability pursuant to 20 C.F.R. § 718.204(c)(1). The preponderance of the pulmonary function study evidence yields qualifying values. Three of the five studies, including the most recent study, yield qualifying values before and after bronchodilator. A fourth study yields qualifying values before bronchodilators. Only one studying did not yield any qualifying values. Thus, the pulmonary function study evidence in the current claim establishes that Claimant is totally disabled.

Total disability may also be established by qualifying blood gas studies under 20 C.F.R. § 718.204(c)(2) (2001). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C. The following blood gas studies were submitted in the current claim:

Exhibit	Date	PCO2	PO2	Qualifying?
DX 13	11/08/01	36 38*	58 68*	Yes No
DX 29	05/08/02	40	68	No
EX 3	04/28/04	32	80	No

*exercise values

Based upon the foregoing, the Claimant has not demonstrated total disability pursuant to § 718.204(c)(2) (2001) of the regulations. The preponderance of the arterial blood gas studies did not reveal qualifying values. Only the 2001 study revealed qualifying values at rest. Thus, the arterial blood gas study evidence does not establish that Claimant is totally disabled.

The final method by which Claimant may establish total disability is through medical opinion evidence wherein a physician has exercised reasoned medical judgment based on medically acceptable clinical and laboratory diagnostic techniques to conclude that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment or comparable employment. 20 C.F.R. § 718.204(c)(4) (2001).

Claimant appeared credible and testified at the hearing that he last worked as a general laborer. He described his job duties as including rock dusting, timbering, cleaning and installing the belt. (TR 21). The Claimant testified that he had to carry timber thousands of feet. (TR 21). Based on this record, it is determined that Claimant performed heavy work. Comparing the exertional requirements of his last coal mining job with the physical limitations demonstrated on this record, it is determined that Claimant has established that he is totally disabled under 20 C.F.R. § 718.204(c)(4) (2001) through a preponderance of the medical opinion evidence of record.

The instant claim includes medical reports from five physicians: Drs. D. L. Rasmussen, Robert Cohen, Daniel Doyle, George Zaldivar and Ben V. Branscomb.

Dr. Rasmussen examined the Claimant on November 8, 2001 for the Department of Labor. (DX 12). Dr. Rasmussen noted the Claimant had a twenty year occupational history of

coal dust exposure, and that Claimant's last coal mine job involved considerable heavy labor. The Claimant's medical history included attacks of wheezing, arthritis in the hands, and high blood pressure. Claimant reported a smoking history starting in 1954 at a rate of a pack of cigarettes a day, but currently only smoking an occasional cigarette. The Claimant reported daily sputum production and cough, wheezing on exertion or when lying down, as well as dyspnea with exertion. Claimant also experiences some substernal chest pain with cough, two pillow orthopnea, and paroxysmal nocturnal dyspnea. The physical examination revealed palpitation, percussion, low diaphragms, and auscultation. The Claimant's breath sounds were markedly reduced, bilateral basilar rales, scattered wheezes and rhonchi were present. An increased expiratory phase with forced respirations was also noted. Dr. Rasmussen's testing revealed pneumoconiosis by x-ray, a moderately severe and partially reversible obstructive impairment by ventilatory study, and moderate resting hypoxia by arterial blood gas study which was normal with exercise. Dr. Rasmussen diagnosed pneumoconiosis based on coal dust exposure history and x-ray evidence. He also diagnosed chronic obstructive pulmonary disease and asthma. Dr. Rasmussen opined that the etiology of the pneumoconiosis and chronic obstructive pulmonary disease is coal dust exposure and cigarette smoking. Dr. Rasmussen concluded that the Claimant has suffered at least minimal loss of lung function, and that he does not retain the pulmonary capacity to perform his last coal mine job. He also determined that coal dust exposure was a significant contributing factor to the Claimant's impairment, and that asthma and cigarette smoking were also factors in his loss of lung function.

Dr Zaldivar, who is board-certified in pulmonary diseases, examined the Claimant on May 8, 2002. (DX 29). Dr. Zaldivar listed an employment history, medical history, and a list of current symptoms. He also listed the medical records which he reviewed.[7] Dr. Zaldivar found that the Claimant suffers from a moderate irreversible airway obstruction, and air trapping by lung volumes, but that he has a normal total lung and diffusing capacities. The physician also found that Claimant has mild resting hypoxemia, which based upon prior blood gas studies with exercise values, was found to be of no significance.[8] Dr. Zaldivar found no x-ray evidence of pneumoconiosis. Dr. Zaldivar diagnosed emphysema due to smoking and asthma. Dr. Zaldivar explained that the Claimant's normal diffusing capacity proved that the airway obstruction was primarily due to asthma because emphysema causes lung tissue destruction which results in reduced diffusion capacity. Dr. Zaldivar believes that the Claimant is capable of performing his last coal mine job and should be treated more intensely for his asthma.

Dr. Cohen, who is board-certified in pulmonary diseases, prepared a consulting report regarding the Claimant on May 10, 2004. (CX 3, 8). An occupational history, a medical history, and smoking history of 46 pack years was obtained. Dr. Cohen reviewed and summarized all three Department of Labor examinations, two examinations performed by Dr. Zaldivar, numerous chest x-rays, pulmonary function studies, and blood gas studies. Dr. Cohen diagnosed pneumoconiosis based on exposure history, symptoms of chronic lung disease, physical examination, x-ray evidence of pneumoconiosis, and evidence of a severe to moderate

7. Dr. Zaldivar summarizes seventeen x-ray interpretations and only six of these interpretations are in the record. Dr. Zaldivar also lists the results of five pulmonary function studies which are not in the record.

8. It should be noted that Dr. Zaldivar did not perform an exercise study due to the miner's increased blood pressure, so this portion of his opinion is based solely upon other testing.

obstructive defect demonstrated in pulmonary function studies. Dr. Cohen stated that even if the total x-ray evidence was interpreted as negative for pneumoconiosis, he would not change his diagnosis due to the clinical and physiological evidence of pneumoconiosis. Dr. Cohen expressly disagreed with Dr. Zaldivar's conclusion that the Claimant's impairment was caused by asthma. He found that the lack of bronchospasm, minimal reversibility in pulmonary function studies, and the consistent presence of a moderate to severe obstruction does not support a finding of asthma. According to Dr. Cohen, Dr. Zaldivar's reliance on a history of wheezing and normal diffusing capacities to make a diagnosis of asthma ignores the missing components and fails to exclude other diseases such as chronic bronchitis. Dr. Cohen offers the opinion that the Claimant suffers from chronic bronchitis as a result of his coal dust exposure based on the Claimant's symptoms and testing results. Finally, based on his measured moderate to severe obstructive lung disease, Dr. Cohen finds that Claimant is totally disabled from his prior heavy coal mine job. Dr. Cohen concluded that smoking and coal dust exposure significantly contributed to the Claimant's impairment.

Dr. Cohen authored a supplemental report, in which the opinions of Drs. Branscomb and Doyle were considered. (CX 8). Dr. Cohen also evaluated the CT scan and found it positive for pneumoconiosis. Dr. Cohen concluded that the additional medical evidence did not change his opinion that the Claimant was totally disabled due to pneumoconiosis.

Dr. Daniel Doyle, a general family physician, has been the Claimant's treating physician since 1990, and currently treats the Claimant every three months.[9] (CX 7). Dr. Doyle authored a report on June 8, 2004 regarding his treatment of the Claimant. Based upon his medical treatment of the Claimant, x-rays and spirometry, Dr. Doyle opined that the Claimant suffers from a totally disabling pulmonary impairment, and that his twenty years of coal mine employment, medical treatment, and x-rays establish that he suffers from pneumoconiosis.[10] Dr. Doyle opined that dust exposure was a significant contributing factor to his pulmonary disease and resulting impairment, although lifelong tobacco use and deconditioning contributed to it.

Dr. Branscomb, who is board certified in internal medicine and specializes in pulmonary medicine, authored a consulting report on June 24, 2004. (EX 4). Dr. Branscomb's report includes an interpretation of a CT scan which finds "no change suggestive of pneumoconiosis." Dr. Branscomb notes an occupational exposure to coal dust in such duration that the development of pneumoconiosis was possible. Dr. Branscomb also found a forty-six pack year smoking history, noted to be sufficient exposure to commonly cause pulmonary and cardiovascular disorders. Dr. Branscomb concluded that the Claimant suffers from asthma and a pulmonary impairments resulting from his asthma and smoking. He finds that Claimant does not suffer from a totally disabling impairment because he would still be able to perform his last coal mine job. Dr. Branscomb believes that the Claimant's impairment may even improve with treatment for his asthma.

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9. Since 1985, Dr. Doyle has served as the Medical Director of the New River Breathing Center, a black lung clinic.

10. Dr. Doyle also reviewed some medical opinions, but failed to specify which opinions were reviewed. Therefore, his comments about these opinions will be disregarded because it is unclear whether these opinions are apart of the evidentiary record.

Drs. Rasmussen, Cohen and Doyle all agree that the Claimant would be unable to perform his last coal mine employment based upon his pulmonary capacity. Dr. Rasmussen found at least a minimal loss of lung function based on pulmonary function studies, and documented the Claimant's prior coal mine job as involving heavy labor. He concluded that the Claimant would be unable to perform his last coal mine job. Dr. Cohen found a severe to moderate obstructive defect. Based on the Claimant's history as a heavy laborer, Dr. Cohen also found the Claimant to be unable to perform his last coal mine employment. Dr. Doyle also found the Claimant to be totally disabled. His opinion is based on his treatment of the Claimant. His treatment records are a part of the record. Drs. Zaldivar and Branscomb opine that the Claimant's asthma is the cause of his impairment and the Claimant would be able to perform his last coal mine employment with treatment. However, neither physician discussed how the Claimant's marked impairment post-bronchodilator would resolve with treatment, especially to the extent of performing sustained heavy labor. Further, Drs. Branscomb and Zaldivar relied, at least in part, on pulmonary function studies which were not in the record when making their determinations. Dr. Branscomb cites relatively high MVVs and good exercise studies as supporting evidence for his conclusions. Only one MVV in the record was not qualifying, and only one exercise study was performed. Dr. Zaldivar cited exercise values which consistently show an improvement in PO2 with exercise. Again, with only one exercise study in the record, Dr. Zaldivar's assessment is based, at least in part, on exercise studies not a part of the record. Thus the opinions of Drs Zaldivar and Branscomb are considered to be not well documented at least as to whether Claimant is totally disabled.

Moreover, Drs Zaldivar and Branscomb couch their opinions that the Claimant could perform his last coal mine job on the condition that he undergo a comprehensive pulmonary treatment program. Their opinion that he would have to undergo a treatment plan to perform his coal mine job undermines their opinion that he is able to do same.

Therefore, the medical opinions of Drs. Cohen, Rasmussen, and Dr. Doyle finding that the Claimant is totally disabled are considered to be better supported by the record. Claimant has established total disability by a preponderance of the pulmonary function studies and the well documented and well reasoned medical opinions submitted in the current claim.

As a material change in condition has been demonstrated by proving by a preponderance of the evidence submitted in the current claim that the Claimant is now suffering from a totally disabling pulmonary impairment, the entire record will be reviewed as to all elements of entitlement.

Existence of Pneumoconiosis and its Etiology

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

(a) For the purpose of the Act, "pneumoconiosis" means "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2001). Moreover, the regulations at 20 C.F.R. § 718.203(b) (2001) provide that, if a Claimant suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2001).[5]

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) (2001) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports

5. There is no autopsy evidence in this record and the presumptions contained at §§ 718.304 – 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[6] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

The following chest roentgenogram evidence was admitted in the current claim:

Exhibit	X-ray Date	Physician	Interpretation
DX 16	11/08/01	Patel, BCR, B	1/0, s/s
DX 17	11/08/01	Binns, BCR, B	Quality only
DX 27	11/08/01	Scatarige, BCR, B	Completely negative
CX 6	11/08/01	Ahmed, BCR, B	1/0, s/p
DX 28	05/08/02	Wheeler, BCR, B	No evidence of pneumoconiosis
CX 5	05/08/02	Miller, BCR, B	1/0, p/p
EX 1	04/28/04	Scott, BCR, B	No evidence of pneumoconiosis

The following chest roentgenogram evidence was in the record from the Claimant's prior claims:

Exhibit	X-ray Date	Physician	Interpretation
DX 1	07/28/93	Daniel, BCR	Completely negative
DX 1	07/28/93	Gaziano, B	Completely negative
DX 2	05/02/00	Navani, BCR, B	Completely negative
DX 2	05/02/00	Ranavaya	0/1, p/q
DX 2	07/19/00	Zaldivar, B	Completely negative

Based on the foregoing x-ray evidence of record, the Claimant has not established that he suffers from pneumoconiosis. The x-ray dated November 8, 2001 was interpreted as positive for pneumoconiosis by two physicians who are dually qualified as Board-certified radiologists and B-readers. The film was interpreted as negative for pneumoconiosis by one dually qualified physician. Therefore, this film is positive for pneumoconiosis by a preponderance of the evidence. The second film, dated May 8, 2002, had been interpreted as positive for the existence of pneumoconiosis by one dually qualified physician, and as negative by another. This film does not establish the existence of pneumoconiosis by a preponderance of the evidence. The final film, dated April 28, 2004, has been interpreted as negative for the existence of pneumoconiosis

6. A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. An "A-reader" is a physician, but not necessarily a radiologist, who submitted six x-ray studies of his or her clients to ALOSH of which two studies are interpreted as positive for the existence of pneumoconiosis, two studies are negative, and two studies demonstrate complicated pneumoconiosis.

by a dually qualified physician. The other films from prior claims do not support a finding of pneumoconiosis. The films dated May 2, 2000 and July 19, 2000 were interpreted as negative for pneumoconiosis. The July 28, 1993 film was also interpreted as negative. Therefore, the x-ray evidence does not establish the existence of pneumoconiosis.

Another method by which Claimant may establish that he suffers from the disease is by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the Claimant's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

As previously detailed, medical reports were admitted in the current claim from Dr. D.L. Rasmussen, Dr George Zaldivar, Dr. Robert Cohen, Dr. Daniel Doyle and Dr. Ben V. Branscomb. The prior claims included the medical reports of three physicians. Dr. John Daniel examined the Claimant on July 28, 1993 for the Department of Labor. (DX 1). Dr. Daniel diagnosed a mild restrictive and obstructive defect based on the Claimant's pulmonary function studies. He found the Claimant's EKG, x-ray, and blood gas studies to be normal. Dr. Daniel diagnosed chronic obstructive pulmonary disease based on the Claimant's history of productive cough. He opined that the Claimant's pulmonary impairment was caused by smoking. Dr. Ranavaya examined the Claimant on May 2, 2000 and diagnosed hypertension. (DX 2). He found no coal dust related diseases, and noted a minimally prolonged expiratory phase with scattered expiratory wheeze. Although the Claimant was short of breath with exertion, complained of wheezing, daily sputum production, and cough, Dr. Ranavaya made no pulmonary diagnoses. Dr. Zaldivar examined the Claimant on May 19, 2000 and diagnosed asthma based on wheezing history and the Claimant's cough worsening with damp weather. (DX 2). Dr. Zaldivar found a moderate irreversible obstructive defect with reduced vital capacity due to air trapping by the Claimant's pulmonary function study. Dr. Zaldivar determined that the Claimant could perform his last coal mine employment due to post-bronchodilator response and that the medication lasted up to six hours.

None of the three medical opinions in the prior claims are determinative. Dr. Daniel's opinion did not provide a rationale for excluding coal dust exposure as a cause of the Claimant's chronic obstructive pulmonary disease, and the opinion was formulated over a decade ago. Dr. Ranavaya provided no rationale to support his conclusions, and his conclusions were not well documented or well reasoned based on the complaints, and history provided by the Claimant, nor

dealt with pulmonary issues revealed during the physical examination. Dr. Zaldivar's report merely provides a historical basis for his subsequent examination and report regarding the Claimant. His diagnosis and findings did not change when he authored his May 8, 2002 report. Three CT scans have been interpreted and made a part of the record. Dr. Scott interpreted a film dated April 28, 2004 and found no evidence of pneumoconiosis. Dr. Branscomb interpreted the same film and found no change suggestive of pneumoconiosis. Dr. Cohen notes in his supplemental report that he finds changes consistent with pneumoconiosis when reviewing the CT scan. The CT scan evidence does not support a finding that the Claimant suffers from pneumoconiosis.

The Claimant has established that he suffers from pneumoconiosis by a preponderance of the evidence. Drs. Rasmussen and Cohen opine that the Claimant suffers from both clinical and legal pneumoconiosis. Dr. Doyle does not clarify whether his diagnoses of pneumoconiosis includes legal pneumoconiosis. The physicians' opinions regarding clinical pneumoconiosis are not supported by the x-ray evidence; however, Drs. Rasmussen and Cohen specifically diagnose legal pneumoconiosis as well as clinical pneumoconiosis. Dr. Rasmussen found specifically that Claimant suffers from legal pneumoconiosis in the form of chronic obstructive pulmonary disease caused by smoking and coal dust exposure. He based his opinion on smoking and coal dust exposure histories, a physical examination and testing results, which revealed a severe partially reversible obstructive impairment. Dr. Rasmussen found coal dust exposure to be a significant contributing factor in the Claimant's loss of lung function. Dr. Cohen found that the Claimant suffered from moderate to severe obstructive lung disease significantly contributed to by coal dust exposure and tobacco smoke. Dr. Cohen also provides a clear rationale for the exclusion of asthma as a cause of the Claimant's impairment, and he specifically stressed that his opinion would remain the same even if the majority of the x-ray evidence was found to be negative for pneumoconiosis.

Drs. Branscomb and Zaldivar report that the Claimant does not suffer from pneumoconiosis but rather his pulmonary impairment is caused by asthma, and that the Claimant also suffers from emphysema. Their diagnosis of the cause of the Claimant's pulmonary impairment were not as well documented or as well reasoned as the opinions on causation of Drs. Rasmussen, Cohen and Doyle. Although they attempt to explain the non-reversible impairment facet of the Claimant's pulmonary function by their diagnoses of emphysema caused by smoking, they never explain how the coal dust exposure history, which is admittedly significant enough to cause pulmonary disability, was excluded as a cause. Dr. Branscomb's diagnosis of asthma was based on "the characteristics, patterns, treatment responses and timing of respiratory findings." Dr. Zaldivar found asthma to be the primary cause due to a normal diffusing capacity, because a normal diffusing capacity reveals no tissue destruction, and while emphysema is destructive of lung tissue, asthma is not.

Dr. Cohen rejected asthma as the cause of the Claimant's pulmonary condition as he found that it did not square with the Claimant's condition. Initially, Dr. Cohen found Claimant's impairment to be at most, "minimally reversible," and that his "post bronchodilator FEV1 never improved beyond the level of moderate impairment, let alone reversal to normal or near normal levels" Dr. Cohen found such minimal reversibility inconsistent with a diagnosis of asthma. He referenced an expert panel report of the National Heart Lung and Blood Institute for the

proposition that asthma is most often fully reversible. He also observed that many patients with COPD have a reversible component to their obstructive lung disease, including those with coal mine dust induced COPD. Dr. Cohen also considered that Claimant has no episodic severe brochospasm which would be indicative of asthma, and that symptoms of cough, sputum production and wheezing are not, in and of themselves, diagnostic of asthma. Dr. Cohen also looked at the normal results of the diffusion capacity test and observed that a normal diffusion capacity is not out of line with his pneumoconiosis as "diffusion capacity can certainly be normal in complicated chronic pneumoconiosis which Mr. Acord has as a result of his coal mine dust exposure."

Dr. Doyle, Claimant's treating physician, agreed with Dr. Cohen that Claimant's pulmonary condition is caused by coal dust exposure not asthma. Dr. Doyle rejected asthma as a cause of the Claimant's condition and, as observed by Dr. Cohen, is in the best position to know the history and nature of his disease over time.

In sum, the well reasoned and well documented opinions of Drs. Rasmussen and Cohen, in concert with the opinion of Dr. Doyle, the Claimant's treating physician, support a finding that the Claimant suffers from pneumoconiosis. The opinions of Dr. Zaldivar and Dr. Branscomb's fail to provide as reasoned a basis for excluding coal dust exposure as a cause of the Claimant's pulmonary impairment. In particular, the medical reports establish the existence of legal pneumoconiosis by a preponderance of the evidence, and the x-ray evidence and CT scan evidence do not disrupt this finding.

Total Disability Due To Pneumoconiosis

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2001). As previously stated, the Claimant established that he is totally disabled based on pulmonary function studies and well reasoned medical opinions. The material change in condition analysis requires that only the evidence submitted in the current claim be evaluated to determine whether the Claimant has established an element of entitlement which was previously adjudicated against him. The Claimant established that he was totally disabled through the newly submitted evidence of record. A de novo review of the record is required after a material change in condition is found. Therefore, the evidence in the prior claims must be evaluated to determine whether the Claimant is totally disabled due to pneumoconiosis.

The following is a summary of the medical evidence of record submitted in the Claimant's prior claims:

Pulmonary function studies:

Exhibit	Date	Height	Age	FEV1	FVC	FEV1 / FVC	MVV	Qualifying?
DX 1	07/28/93	67.5"	56	2.10 2.40*	3.20 4.43*	66% 54%	82 139*	No No
DX 2	05/02/00	67"	63	1.75	2.48	71%	43.6	Yes

				1.87*	2.76*	68%	35.7*	No
DX 2	07/19/00	68"	63	1.88 1.92*	3.19 3.47*	59% 55%	78 88	No No
DX 2	07/25/00	68"	63	1.54 1.82*	2.35 2.84*	65% 64%	64.3 75.5	Yes No

*results post-bronchodilator

Blood gas studies:

Exhibit	Date	PCO2	PO2	Qualifying?
DX 1	07/28/93	35.8 36.1* 37.0* 35.3*	69 85* 85* 87*	No No No No
DX 2	05/02/00	40.1 39.4*	70.1 89.7*	No No
DX 2	07/19/00	37 44*	79 86*	No No

*exercise values

Medical Opinions:

Dr. Zaldivar found the Claimant to be able to perform his last coal mine employment under the same rationale as provided in his subsequent report which was previously summarized. Dr. Ranavaya failed to make any findings regarding the Claimant's pulmonary condition. Dr. Daniel found no disability in 1993. Dr. Daniel's opinion is of historical significance, but because pneumoconiosis is a chronic and progressive disease, it is not current enough to help in the determination of total disability.

After reviewing the record in its entirety, the Claimant has established that he is totally disabled due to pneumoconiosis. The rationale provided in the material change in condition analysis has not been disturbed by the evidence in the Claimant's prior claims. The progressive nature of the disease and the current qualifying pulmonary function studies are not contradicted by prior non-qualifying studies. The final study taken by the Claimant in his previous claim was qualifying, and six of the ten most recent studies are qualifying. Therefore, the Claimant has established total disability by his pulmonary function studies. The medical opinions support this finding. Claimant's pulmonary impairment has been found to be totally disabling by the well reasoned medical opinions of Drs. Cohen, Doyle, and Rasmussen. Drs. Zaldivar and Branscomb's opinions are not assessed any additional weight based on evidence in the prior claim.

The Claimant has established that he is totally disabled due to pneumoconiosis.

Pneumoconiosis must be a "substantially contributing cause" to the Claimant's total disability. 20 C.F.R. § 718.204(c)(1) (2001). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2001).

The medical opinions establish that the Claimant's impairment was substantially related to his coal dust exposure. Drs. Cohen, Doyle, and Rasmussen found coal dust exposure to have substantially contributed to the Claimant's pulmonary impairment. The medical reports in the prior claims by Drs. Ranavaya, Daniel, and Zaldivar did not diagnose pneumoconiosis, but their opinions on the cause of Claimant's total pulmonary disability are entitled to little weight in light of their failure to recognize a pulmonary disability, and the progressive nature of the disease.

Onset of Benefits

Claimant is entitled to benefits commencing on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the Claimant filed his claim which, in this case, is September of 2001. 20 C.F.R. § 725.503 (2001); *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). In a subsequent claim, the claim is considered a new claim and its filing date is the earliest date that benefits can be awarded. § 725.309(d)(5) (2001). Moreover, it is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the Claimant became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310 (1984).

Upon review of the record in this case, it is determined that the onset date cannot be determined from the medical evidence and, therefore, benefits are payable from September 1, 2001, the month in which the Claimant's claim was filed. Accordingly,

ORDER

IT IS ORDERED that the claim for benefits filed by Hiram Acord is granted and the payment of benefits shall commence as of September 1, 2001.

IT IS FURTHER ORDERED that within 30 days of the date of issuance of the *Decision,* Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20

C.F.R. § 725.366 (2001). Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel within 20 days of receipt of the petition for fees and costs. It is requested that the petition for services and costs clearly state (1) counsel's hourly rate and supporting argument or documentation therefor, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.